TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ETMC FIRST PHYSICIANS

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-17-1978-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the primary reason for the visit was related to the patients work related injuries."

Amount in Dispute: $678.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In reviewing the report, it is the carrier's position that there is an extent of injury issue for this date of service... The claimant's treatment was not for the compensable injury, but rather [injury] that is not related to the compensable injury."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 7, 2016	99284-25 and 93010	$678.00	$197.17

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code 134.203 sets out the fee guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Workers' compensation jurisdictional fee schedule adjustment
   - 2 – The charge for the procedure exceeds the amount indicated in the fee schedule

Issues

1. Did the insurance carrier raise the issue of extent of injury during the bill review process?
2. Are the insurance carrier's reason(s) for denial or reduction of payment supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 99284-25 and 93010 rendered on July 7, 2016. The respondent, AIG argued in its position statement on behalf of New Hampshire Insurance Company, "...there is an extent of injury issue for this date of service... The claimant's treatment was not for the compensable injury, but rather [injury] that is not related to the compensable injury." New Hampshire Insurance Company's failure to issue an explanation of benefits to the requestor raising the extent of injury issue, creates a waiver of defense that AIG raised in its response to medical fee dispute resolution. Under 28 Texas Administrative Code §133.307 (d)(2)(F), which states "The [carrier's] response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review..."

   Absent any documentation that AIG raised defenses that conform with the requirements of 28 Texas Administrative Code §133.307 (d) (2) (F), the division concludes that the defenses presented in AIG's position statement, shall not be considered for review pursuant to 28 Texas Administrative Code §133.307 (d) (2) (F).

2. The insurance carrier denied the disputed services with claim adjustment reason code(s): "1 – Workers' compensation jurisdictional fee schedule adjustment" and "2 – The charge for the procedure exceeds the amount indicated in the fee schedule." Review of the explanation of benefits (EOB) presented by the requestor does not reflect a payment issued for the disputed services as indicated with denial reason code "1" and "2". No other or additional EOBs were presented for consideration in this review. As a result, the division finds that the insurance carrier's denial reasons raised on the EOBs are not supported and the disputed services are considered for review pursuant to 28 Texas Administrative Code §134.203.

3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   Procedure code 99284, service date July 7, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2.56 multiplied by the geographic practice cost index (GPCI) for work of 1 is 2.56. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 0.92 is 0.4876. The malpractice RVU of 0.23 multiplied by the malpractice GPCI of 0.822 is 0.18906. The sum of 3.23666 is multiplied by the Division conversion factor of $56.82 for a MAR of $183.91.

   Procedure code 93010, service date July 7, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.17 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.17. The practice expense (PE) RVU of 0.06 multiplied by the PE GPCI of 0.92 is 0.0552. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.00822. The sum of 0.23342 is multiplied by the Division conversion factor of $56.82 for a MAR of $13.26.

   The Division finds that the requestor is entitled to a total recommended amount of $197.17. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $197.17.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $197.17 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

			April 7, 2017
Signature		Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.